Fairfax County Park Authority
Children's Emergency and Medical Information

Child's Name:_____ DOB:__/__/__/__/__/__/__/__
Last First MI MO DAY YR

Address:_____
Street City State Zip
Phone (h):_____

Parent/Guardian Name:_____E-Mail_____
Last First MI
Address:_____
Street (if different from child's) City State Zip
Phone (h)_____ (w)_____

Parent/Guardian Name:_____E-Mail_____
Last First MI
Address:_____
Street (if different from child's) City State Zip
Phone (h)_____ (w)_____

**Mandatory 2 Emergency Contacts other than parents (required by the VA Dept of Social Services)

Emergency Contact #1_____Relationship to Child_____

Address_____Phone (H)_____ (W)_____

Emergency Contact #2_____Relationship to Child_____

Address_____Phone (H)_____ (W)_____

Child's Physician (name & phone)_____

Insurance Company (name & policy #)_____

___Yes ___No Is your child under physician's care or taking medications on a continuing basis? If yes, please explain what for.

___Yes ___No Does your child have a contagious disease? If yes, please describe.

___Yes ___No Does your child have any allergies? If yes, please specify allergies.

What should be done if your child comes into contact with an allergen?_____

___Yes ___No Does your child have any chronic problems, special needs, or other conditions we should know about? If yes, please explain.

___Yes ___No Does your child take medications? If yes, please list. If during camp, you must contact Youth Services for proper medical authorization forms.

___Yes ___No Do you give your child permission to participate in swimming/wading activities in water at the program site?

___Yes ___No Can your child swim in water above his/her shoulders?

What schools or other programs does your child attend?_____

(continued on next page)

I hereby authorize the FCPA and/or designated contractor to seek medical treatment for my child, at the nearest facility, in the event medical care is required. In the event non-emergency medical care is required, I authorize the FCPA to seek medical treatment through my child's physician. I understand that I am responsible for medical expenses incurred by my child and that FCPA advises that I carry health insurance for my child. I have read the policies for the program and agree to adhere to them, including the policy if my child becomes ill, I must pick up my child immediately. I certify that the above information is complete and correct.

Parent/Guardian's Signature Date

IMMUNIZATION RECORD (must be completed for camp or a copy signed by a physician must be attached to this form)

IMMUNIZATIONS	**RECORD COMPLETE DATES (month, day, year) OF VACCINE DOES ADMINISTERED**				
Diphtheria/Tetanus/Pertussis(DTP)	/ / /	/ / /	/ / /	/ / /	/ / /
Diphtheria/Tetanus (DT or Adult Td)	/ / /	/ / /	/ / /	/ / /	/ / /
Poliomyelitis (OPV or IPV)	/ / /	/ / /	/ / /	/ / /	/ / /
Measles (Rubeola)	/ / /	/ / /	/ / /		
Rubella	/ / /	/ / /	/ / /		
Mumps	/ / /	/ / /	Before 08/01/81 / / /		
Measles, Mumps, Rubella (MMR)	/ / /	/ / /			
Hepatitis B Vaccine	/ / /	/ / /	/ / /	Other:_____	/ / /

Haemophilus influenzae Type b (Hib Conjugate): PLEASE COMPLETE THE APPROPRIATE SECTION BELOW.

/ / Has received complete series of Hib vaccine in accordance with current recommendations of the AMERICAN ACADEMY OR PEDIATRICS OR THE U.S. PUBLIC HEALTH SERVICE.

/ / Has received the AGE APPROPRIATE doses of Hib vaccine as recommended by the AMERICAN ACADEMY OF PEDIATRICS OR THE U.S. PUBLIC HEALTH SERVICE, the series will be completed on (RECORD COMPLETE DATE (month, day, year):

Series Completion Date: / / /
MO DAY YR

/ / Hib vaccine is not indicated because this child has had Hib disease at 24 months of age or older.

/ / Being over 30 months of age, this child is not required by law to have proof of immunization against Hib.

I certify that this student is ADEQUATELY IMMUNIZED in accordance with the MINIMUM requirements for attending programs licensed by the VA Dept of Social Services.

Name and Address of Physician/Health Dept_____

Signature of Physician or Health Dept. Official: _____; Date (mo, day, yr):/ / /

PHYSICAL RECORD (required if child is attending the program for more than 30 days)

Date of Most recent Physical_____

Findings:_____

This child appears to be in good physical health and free of communicable disease.

Name and Address of Physician/Health Dept_____

Signature of Physician or Health Dept. Official: _____; Date (mo, day, yr):/ / /